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ABSTRACT

This fact sheet outlines some demographic trends that are influencing the cost and availability of health care for children and making it increasingly necessary to take action to improve the health of the nation's children. In recent years children, as a group, are more likely to be poor, lack health insurance, have working mothers, receive inadequate prenatal care, suffer from communicable diseases, and become victims of violence, abuse, and neglect than in the 1960s and 1970s. Infant mortality, teenage pregnancy, substance abuse, and high school dropout rates in the United States are also very high in comparison to rates in other developed nations. All of these trends have a negative effect on industrial productivity, and on the ability of young adults to find secure, well-paying jobs. Health care plans that promote healthy children are a wise business investment, since parents of healthy children miss less work time and have higher morale. Healthy children also make better students and are more likely to become productive workers. Overall, employers will benefit from higher employee morale, lower turnover, and reductions in health care costs, absenteeism, accidents, and workers' compensation claims. Contains 28 references. (MDM)

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Washington Business Group on Health

777 N. Capitol Street N.E. Suite 800 Washington, D.C. 20002 (202) 408-9320 TDD (202) 408-9333 FAX (202) 408-9332

The Competitiveness and Productivity of Tomorrow's Work Force: Compelling Reasons for Investing in Healthy Children

EMPLOYER HEALTH-CARE COSTS

American employers spent approximately $225 billion for health care benefits in 1991 and an additional $50.6 billion in workers' compensation.[1] For most, expenses related to childbirth were the single largest component of health care costs,[2] ranging from 10% to 49% of all expenses.[3] These figures alone, however, do not reflect the substantial, related costs of absenteeism, short-term disability, and lost productivity due to illness.[1]

By 1992, employer health-care costs had risen 10.1%, representing half of company profits, or an average cost of $3,968 per employee. This increase, although considerable, was still less than the 14.9% average annual rate of increase between 1987 and 1991. The lower 1992 rate primarily reflects a shift in the health insurance programs being offered to employees, from the traditional indemnity plans to managed care plans.[4]

DEMOGRAPHIC TRENDS

Children

Poverty. For the first time in American history, children comprise the nation's poorest group.[5] Poverty among children fell during the 1950s and 1960s, rose again during the 1970s and 1980s, and has remained high into the 1990s.[5] In 1991, more than 16.2 million children (close to one in five) under 21 years lived in poverty.[6]

Black and Hispanic children are two to three times more likely to live in poverty than whites.[7] However, the belief that most poor children in America are from inner-city minority families on welfare is a myth. Only about 10% of poor children fit that description.[5] Indeed, poverty among whites rose from 9.7% in 1973 to 15.6% in 1992, the highest rate of increase for any racial group.[6]

Lack of health care. Children have unique health needs that must be tended to when those needs occur, not later when the disease may have become chronic or its effects intractable. How much health care are the poorer children in this nation getting? One indication of a family's access to health care is the frequency of physician visits.[5] In 1991, about

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21% of children under 20 years of age, or 13.4 million children, had not been seen by a physician in the past year.[8]

The average cost of health care per child in America is about half of that for adults and a seventh of that for the elderly.[9] But in 1991, of the 76.5 million children in America under 21 years, at least one out of six had no health coverage at all.[6,10] American children are less protected against poor health than their Western European counterparts,[11] with blacks and Hispanics particularly lacking health coverage.[7]

Changing Work Force

Diversity. By the year 2005, changes in the work place will be dramatic. Leaving the work force in great numbers right now are white males, traditionally the most prominent and most educated group of our workers. Of the net additions (entrants minus leavers) to the work place in 2005, Hispanics will represent 27%; blacks, 15%; and Asians, 12%. White men will be filling only 15% of the jobs becoming available; the remaining slots will be taken by white women.[12]

Working mothers. The number of women in the work force has grown almost every decade since the 1890s, but the rate of growth from 1970 to 1991 was unprecedented.[5] In 1991, 58.4% of mothers with preschool-age children were working, nearly double the 1970 level. During the same period, working mothers of school-age children increased from 43% to 74.4%.[8]

Fifty-five percent of working women are in their childbearing years. In 1990, 53% of women who had had a baby in the past year were in the work force.[13] But many are not insured for maternity care, either because they do not have any health insurance or because their private insurance policies do not cover maternity care.[5]

New mothers tend to remain in the work force more and more. Women with some college education, and those with more work experience, leave the work force later in their pregnancy and reenter sooner than do women with less education or experience.[14]

Many women find it inconvenient to continue breastfeeding once they return to work. However, research now suggests that mothers whose employers make it convenient for them to breastfeed take less time off from work because their babies are healthier than formula-fed babies.[15] In the first year of life, babies who are breastfed suffer fewer and less serious respiratory and gastrointestinal illnesses and fewer food aller-

gies.[16] Evidence also suggests that lactation may protect the mothers from ovarian and breast cancer.[17,18]

Childhood illness is a major cause of employee absence. In a 1990 survey, about half of employed mothers who reported that her child had been sick in the last month missed work to care for that child. Children under 12 years average five days of sickness per year; mothers are far more likely than fathers to miss work because of a sick child.[14]

HEALTH INDICATORS

Prenatal Care

Twenty-five percent of American babies are born to women who receive inadequate prenatal care. These women are about three times more likely to deliver a low birth weight baby than women who receive adequate prenatal care.

Low birth weight (less than 5.5 pounds) and very low birth weight (less than 3.3 pounds) are the leading correlates of infant death or lifelong disability.[5] Studies show that low birth weight is also connected to poor school performance.[19]

Among the preventable causes of low birth weight are lack of prenatal health care, poor nutrition, and substance abuse, including smoking.[20]

Every newborn carried to term in 1990 as a result of better prenatal care saved an average of $21,000 in hospital costs during the neonatal period alone, not to mention the long-term health costs associated with many babies whose mothers receive inadequate prenatal care.[21]

In 1989, 20% of all mothers smoked during pregnancy, doubling their risk of bearing a low birth weight baby. Nearly 20% of pregnant women use one or more illegal substances at some point during the prenatal period,[21] leaving their babies prone to serious physical and mental disabilities, behavioral problems, and learning impairments.[5]

About 21% of pregnant women drink alcohol. Drinking during pregnancy, especially heavy drinking, is associated with miscarriage, low birth weight, and fetal-alcohol syndrome, the last the most common cause of mental retardation.[21]

Infant Mortality

Infant mortality is a key indicator of the health of women before and during pregnancy and the quality of primary health care that they and their infants receive. It is the most reported child-health measure worldwide.[7]

The U.S. provisional 1991 rate–8.9 per 1,000 live births–was the lowest in our history.[6] But 22 other industrialized countries have lower rates. Japan has the lowest of all. Infants in Belgium, France, Germany, Hong Kong, Ireland, Italy, the Netherlands, Singapore, Spain, and Switzerland, among others, have better survival rates than those in the United States.[22]

In 1990, the most recent year for which a breakout by race is available, black babies died at more than twice the rate of white babies–18 per 1,000 compared to 7.6 per 1,000 for white babies.[6]

Low birth weight was the leading killer of black infants. Birth defects claimed more white infants. One baby out of five who dies before the first birthday succumbs to a birth defect, the leading cause of infant mortality in America now that many other causes have been reduced. Some birth defects are preventable, e.g., abstinence from alcohol and taking folic acid vitamin supplements during pregnancy can prevent a host of problems. Putting an infant with the genetic disorder phenylketonuria on a special diet can circumvent mental retardation.[23]

Illness

The lower the family income, the more days of school a child age 5 to 17 loses. For example, a child from a family earning $10,000 or less misses an average of 6.9 days of school per year, but a child from a family earning $35,000 or more misses an average of only 4.8 days.[24]

Communicable diseases. Many preventable diseases are on the rise among children and adolescent–in part because, after rapidly improving in the 1960s and 1970s, immunization rates among young children slumped during the 1980s. The federal government suspended data collection on immunization rates among preschool-age children in 1985,[5] but data until then indicate that U.S. rates lagged behind Western European rates by 23% to 49%.[11] Most experts believe that, in 1991, only about 70% of 2-year-olds had received vaccines for polio, diphtheria, rubella, measles, and mumps.[5] In 1990, 26,000 cases of measles alone were reported, a huge increase over the 1981–88 average of only 3,000 a year. Nearly 100 deaths from measles were reported in 1990.[5]

Lead exposure. The number of children with elevated blood lead-levels has declined substantially over the past 20 years. However, in 1990, approximately 3 million children under age 6 still had unacceptable levels. Harmful effects include decreased intelligence, impaired hearing and neurobehavioral development, and stunted stature or growth.[8]

Chronic conditions. In 1991, more than 4.1 million (6%) children ages 1 to 19 were limited in their usual activities because of chronic illness and impairment.[8] These limitations are more frequent among males than females, among blacks than whites, and among young children from low-income families than those from more affluent ones.[24] And because children with chronic conditions miss more school days than healthier children, the situation creates a burden for working parents.

With AIDS growing rapidly among the heterosexual population,[7] infants are one of the fastest growing groups of AIDS patients.[8] AIDS has a long latency period, up to 9 years. Thus, most of the 8,911 young adults ages 20 to 24 reported as infected as of June 1992–10 times as many as reported for adolescents as of 1991–were actually exposed to HIV in their teens.[7,8]

Injury

Historically, child mortality due to natural causes (i.e., diseases, including birth defects) has declined dramatically. But the mortality rate due to injury has steadily increased.[25] Unintentional injury is now the leading cause of death in all children after age 1.[5] About 75% of child deaths due to injury are caused by unintentional injury; motor vehicle collisions cause the most.[25]

Violence

Violent crime involving teenagers either as victims or as perpetrators has exploded in recent years at a faster rate than crime involving adults. Including homicide and suicide, violence is responsible for 25% of child deaths due to injury.[25] Much of adolescent violence is related to the illegal drug trade. Arrest rates for rape and aggravated assault have increased in the last decade by approximately 40% and 66%, respectively.[5]

Homicide is the fourth leading cause of death in children ages 1 to 9. For adolescents 10 to 14 years old, it ranks third; for 15- to 19-year-olds, it is the second leading cause of death, over eight times higher for blacks than for whites.[8]

The suicide rate among adolescents ages 10 to 19 increased 30% between 1980 and 1989. By 1991, as many as 1 in 12 high school students attempted suicide.[5] For 15- to 19-year-olds, the rate of suicide is almost twice as high in whites as in blacks.[8]

Abuse and Neglect

About 2.7 million children were reported to state authorities as being abused or neglected in 1991–an increase of 6% since 1990 and 40% since 1985. Economic stress and substance abuse are frequently contributing factors.[5] (Better recognition of neglect and improved reporting systems may also be related to the recent increase in reports.)

Substance Abuse

Despite recent reductions in adolescent alcohol and drug use, a disturbingly high proportion of teenagers still use these substances.[5] Alcohol continues to be the most widely abused substance among youth ages 12 to 17. In 1991, 20.3% of this group reported using alcohol in the previous month.[8] Fifty-four percent of high school seniors, however, reported consumption. (School dropouts were not surveyed, so estimates may understate the problem.[5]) In 1991, 10.8% of teenagers reported smoking in the last month.[8]

Mental Health

National estimates of the prevalence of mental disorders in children are not yet available. However, several community epidemiologic research studies indicate that approximately 20% of children under 18 years suffer from a mental disorder, coupled with measurable impairment in overall functioning. A possible 3% may suffer from a serious mental disorder, accompanied by functional impairment in family, school, or community activities. Analyses of costs attributed to mental disorders in children and youth are now underway.[26]

Teenage Pregnancy

Today, roughly one in five teenage girls is expected to have at least one baby by age 20.[5]

Because teenage mothers are less likely to finish high school than teenagers who do not have children[5] and less likely than other mothers to receive prenatal care,[8] teenage pregnancy has an adverse effect on two generations.

EDUCATION

One out of three 6-year-olds today is not prepared for formal education.[19] Once in school, untold numbers fail to learn adequately because they come to school hungry, suffer neglect or abuse at home, or have birth defects and illnesses that–in this nation with the best medicine in the world–could have been prevented or better treated. Disabling conditions, substance abuse, and teenage pregnancy are among the major factors that contribute to poor academic performance and high dropout rates.[5]

The percentage of young adults dropping out of high school declined significantly in past decades, although that decline has slowed since 1975. In 1990, 12% of young adults dropped out of high school: 9% of whites, 13.2% of blacks, and 32.4% of Hispanics.[8] The Hispanic dropout rate has tended to remain stationary.[27]

The job outlook for high school dropouts is poor: In October 1989, only 47% of those who had dropped out in the previous year were employed,

compared to the 85% employment rate of high school graduates not going on to college.[27]

PRODUCTIVITY

As technology advances, blue-collar jobs are dwindling rapidly. The fastest-growing occupations are those that demand at least a high school education.[12] In 1987, only 22% of new jobs required a college degree; by the year 2000, college will be a prerequisite for one-third of the new jobs.[5]

For example, higher-paying jobs were a possibility for those with less than a high school education until 1979, when manufacturing was an increasing source of employment growth. By 1990, the industry had lost 2 million positions from its 1979 peak of 21 million. Today the manufacturing jobs that are left increasingly demand more professional and technical education.[28]

Among the major occupational groups, workers at each level of education will continue to have higher median earnings than those at the next lower level. Income, in turn, is tied to productivity: within each occupation, the most valuable employees (i.e., the most productive ones) are paid the most. Many of the occupations expected to grow faster than average between 1990 and 2005 are among those that demand higher levels of education and promise greater earnings.[28]

CONCLUSION

Health care plans that promote healthy children are a wise business investment. Parents of healthy children, especially mothers, have less reason to miss work than other parents. Their children make better students and grow up to be healthier and more productive throughout their working lives; it also stands to reason that their employers will benefit from increased employee morale; lower turnover; and reductions in health care costs, absenteeism, accidents, and workers' compensation claims.[12]

As the diversity of our work force grows, assuring universal access to prenatal and child health care in America is one of the most cost-effective measures our society can take. Tomorrow's work force, after all, is growing up today.

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